

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 91
No. 200

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Cecil</i>	MARYLAND	STATE <i>Pa.</i>	COUNTY <i>Lancaster</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Carlisle</i>	LENGTH OF STAY (in this place) <i>just today</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Piquette, R.D.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>158-3</i>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
<i>Ralph Gordon Armstrong</i>		<i>1 7 19 56</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH
<i>M.</i>	<i>White</i>	<i>Married</i>	<i>7-7-1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Retired</i>		<i>Carpenter</i>	<i>Lancaster Co. Pa.</i>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Oliver Armstrong</i>		<i>Susie McMillan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>no</i>	
		17. INFORMANT & ADDRESS: <i>Leonard Armstrong, Willow Street</i>	

18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Acute Coronary Thrombosis</i>		
An antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		
19a. DATE OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>R. L. Woodson</i>		DATE SIGNED <i>1-7-56</i>
23. BURIAL, CREMATION, REMOVAL (Specify):		24. FUNERAL DIRECTOR
<i>burial</i>		<i>Edmund Millington, Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	ADDRESS
<i>Jan. 7, 1956</i>	<i>Edmund Millington</i>	<i>158-3</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 17 1956

BUREAU V. S.

478

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>New Jersey</u>	COUNTY <u>Salem</u>
CITY (If outside corporate limits, write RURAL and give nearest town), OR TOWN <u>ELK Mills</u>	LENGTH OF STAY (in this place) <u>1 1/2 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town), OR TOWN <u>Deep Water</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>106 Harrison St.</u>	1

3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Henry</u> (Last) <u>Aument</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>29</u> <u>1956</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 24, 1889</u>		9. AGE last birthday: <u>66</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machine Operator Dupont Chem. Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Dupont Chem. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME: <u>George W. Aument</u>		
14. MOTHER'S MAIDEN NAME: <u>ELLA B. Torbert</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>146-05-7741</u>			17. INFORMANT & ADDRESS: <u>George Aument, Newark, Del.</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis (2nd attack)</u>		<u>None</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cerebral thrombosis (1st attack)</u>		<u>2 weeks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 12, 1955, to Jan 29, 1956, that I last saw the deceased alive on Jan 13, 1956, and that death occurred at 5:30 P M, from the causes and on the date stated above.

SIGNATURE <u>J. Ralph Andrews Jr.</u>	ADDRESS <u>Elkton, Md.</u>	DATE SIGNED <u>Jan. 20, 1956</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>	DATE THEREOF <u>2/1/56</u>	NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Methodist Ch.</u>
LOCATION (City, town, or county) (State) <u>Cherry Hill, Md.</u>	DATE REC'D BY LOCAL REGISTRAR <u>Feb 1</u>	REGISTRAR'S SIGNATURE <u>H. S. Rager</u>
24. FUNERAL DIRECTOR <u>W. Walter du Bois, Jr.</u>	ADDRESS <u>Elkton, Md.</u>	

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RECEIVED
FEB 2 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Liberty Grove Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Liberty Grove Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Margaret Pearl Bancroft</u>		OF DEATH: <u>Jan. 9 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Sept. 11, 1880</u>
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<u>75</u> yrs.		<u>Housewife</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Liberty Grove Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Isaac Griest</u>		<u>Mary Caldwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Mrs. Ross Montgomery Liberty Grove</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		IMMEDIATE CAUSE (A) <u>Carcinoma Uterus -</u>	
		ANTECEDENT CAUSE (S) <u>General Metastasis -</u>	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Myocarditis -</u>	
		(C)	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
		<u>3 yrs</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1954</u> to <u>Jan 8, 1956</u> that I last saw the deceased alive on <u>Jan 8, 1956</u> and that death occurred at <u>5:30</u> M. from the causes and on the date stated above.			
SIGNATURE <u>E. J. Hanson</u>		DATE SIGNED <u>1/11/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Burial</u>		<u>Jan. 12, 1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Harmony Chapel Cem.</u>		<u>Rowlandville Md.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>J. E. Tyson</u>		<u>Rising Sun Md.</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 12 1950

BUREAU V. S.

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General Material
Letter

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

480 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00461
Item 18 Film GL92 2-8-56 ams
CERTIFICATE OF DEATH Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil MARYLAND				STATE Maryland COUNTY Cecil			
CITY (If outside corporate limits, write RURAL OR, and give nearest town) Perry Point				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perry Point (V.A. Hospital)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) ANTONIO (NMI) BENEDITTO				4. DATE (Month) (Day) (Year) OF DEATH: January 27 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 8-5-75	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown			10B. KIND OF BUSINESS OR INDUSTRY: Unknown	11. BIRTHPLACE (State or foreign country): Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes Philippine			16. SOCIAL SECURITY No. Unknown	17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Hemorrhage subdural subarachnoid, massive						5 to 6 days	
ANTECEDENT CAUSE (S) due to trauma						5 to 6 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. Part II Fractures multiple, of the skull						7 to 10 days	
(C) Pneumonia lobar unresolved, right lower lobe						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis generalized							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-3 , 19 24 , to 1-27 , 19 56 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Director, Professional Services M.D. VAH, Perry Point, Md.				ADDRESS 1-31-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-31-56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2-1-56		REGISTRAR'S SIGNATURE Isrene E. Laugherty		24. FUNERAL DIRECTOR Pennington & Son, Hayre de Grace, Md.			

RECEIVED

FEB 3 1956

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

481

CERTIFICATE OF DEATH

00462

Reg. Dist. No. 97

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Indiana</u>		COUNTY <u>Ripley</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bainbridge</u>		<u>3 days</u>		TOWN <u>Madison</u>		<u>52 x - 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Gertrude</u>		(Middle) <u>Doll</u>		(Last) <u>Benham</u>		(Month) <u>1</u> (Day) <u>18</u> (Year) <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 4, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Deceased (unknown)</u>				14. MOTHER'S MAIDEN NAME <u>Deceased (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>----</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT & ADDRESS <u>Navy Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>CEREBRAL VASCULAR ACCIDENT GENERALIZED</u>				INTERVAL BETWEEN ONSET AND DEATH <u>APPROX.</u>			
ANTECEDENT CAUSE(S) DUE TO <u>ARTERIOSCLEROSIS</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>----</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>----</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>1-15</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>19 56, to 1-18, 19 56, that I last saw the deceased alive on 1-18, 19 56, and that death occurred at 4:10 P.M. from the causes and on the date stated above.</u>			
22. I hereby certify that I attended the deceased from <u>1-15</u> , 19 <u>56</u> , to <u>1-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>56</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.				DATE SIGNED <u>1-19-56</u>			
SIGNATURE <u>H. Till Lt MC USNR</u>				ADDRESS (Street, city, town, state) <u>Bainbridge, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal & Burial</u>		DATE THEREOF <u>1-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>Benham Cemetery</u>		LOCATION (City, town, or county) (State) <u>Benham, Indiana</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dorothy B. Bramble</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Patterson & Son, Perryville, Md</u>		ADDRESS	
DATE <u>1-18-56</u>							

CERTIFICATE OF DEATH

181

00108

REG. NO. 1001

A. USUAL RESIDENCE (Place of Birth)

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

WATER

SEWER

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

INTERMEDIATE CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

NAME OF PATHOLOGIST

NAME OF BACTERIOLOGIST

NAME OF RADIOLOGIST

NAME OF CLINICAL PATHOLOGIST

NAME OF LABORATORY

NAME OF HOSPITAL

NAME OF NURSING HOME

NAME OF PRIVATE HOME

NAME OF OTHER PLACE

NAME OF PLACE OF BIRTH

NAME OF PLACE OF DEATH

NAME OF PLACE OF BURIAL

NAME OF PLACE OF CREMATION

NAME OF PLACE OF INTERMENT

NAME OF PLACE OF REINTERMENT

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JAN 23 1936

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DEATH RECORD

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00463

482

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Port Deposit</i>		LENGTH OF STAY (in this place) <i>Life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		TOWN <i>Port Deposit</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rock Run</i>				STREET ADDRESS (If rural, give location) <i>Rock Run</i>			
3. NAME OF DECEASED (Type or Print) <i>George</i> (First) <i>Body</i> (Middle) (Last)				4. DATE OF DEATH <i>JAN - 19 19 56</i> (Month) (Day) (Year)			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col -</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Nov - 28 - 1868</i>	9. AGE last birthday <i>87</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>GENERAL</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Rev. George J. Body</i>				14. MOTHER'S MAIDEN NAME <i>Nancy O. Jones</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Estell Jennifer, Port Deposit, Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Paralysis Rt Side -</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arterio-sclerosis.</i>				8 yrs -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov - 10 - 55</i> to <i>Jan 19, 1956</i> , that I last saw the deceased alive on <i>Jan 9, 1956</i> , and that death occurred at <i>9 A.</i> M. from the causes and on the date stated above.							
SIGNATURE <i>G. J. Benson</i>		M. D. <i>Port Deposit, Md.</i>		DATE SIGNED <i>1/20/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-21-1956</i>		NAME OF CEMETERY OR CREMATORY <i>Mt Zoar</i>		LOCATION (City, town, or county) (State) <i>Conowingo, Md</i>	
24. REC'D BY REGISTRAR <i>1-22-1956</i>		REGISTRAR'S SIGNATURE <i>James E. Dougherty</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson & Son</i>		ADDRESS <i>Perryville, Md</i>	

108403

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

483

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX
4. AGE
5. DATE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MEDICAL HISTORY
9. HISTORY OF PRESENT ILLNESS
10. HISTORY OF PREVIOUS ILLNESSES
11. HISTORY OF SURGERY
12. HISTORY OF DRUGS
13. HISTORY OF ALCOHOL
14. HISTORY OF TOBACCO
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BUREAU V. S.

JAN 21 1956

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKTON</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural Elkton RD 3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>Robert Allen Brinkley</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>24</u> <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Sept. 23, 1956</u>	
9. AGE last birthday <u>4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William T. Brinkley</u>				14. MOTHER'S MAIDEN NAME: <u>Flossie Murdock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT & ADDRESS: <u>William T. Brinkley</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pertussis</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 12</u> , 1956, to <u>Jan. 24</u> , 1956, that I last saw the deceased alive on <u>Jan. 23</u> , 1956, and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Ralph Andrews Jr.</u>		M. D. <u>Elkton Maryland</u>		DATE SIGNED <u>1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkton Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 26</u>		REGISTRAR'S SIGNATURE <u>FR. Trauer</u>		24. FUNERAL DIRECTOR <u>H. Walter du Bose Jr</u>		ADDRESS <u>Elkton, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 5

JAN 27 1956

RECEIVED

483

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Halifax</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Perry Point</u>		<u>4 yrs. 19 days</u>		TOWN <u>Clover</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD# 1, Box 125</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>WILLIAM B. CARRINGTON</u>				<u>January 27, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Negro</u>	<u>Married</u>	<u>Oct. 26, 1895</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>			<u>self-employed</u>	<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>JESSE CARRINGTON</u>				<u>GEORGANNA EASLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u> <u>WW-I</u>		<u>Unknown</u>		<u>Hospital Records, VAH., Perry Point, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Auricular fibrillation</u>						<u>1 hr.</u>	
ANTECEDENT CAUSE (S) (B) <u>Cardiac arrest</u>						<u>15-20 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Lobectomy, left upper lobe</u>						<u>2 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Tuberculosis pulmonary</u>						<u>unknown</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 8</u> , 1952, to <u>Jan. 27</u> , 1956, the deceased was last seen alive on <u>Jan. 27</u> , 1956, and that death occurred at <u>2:43 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. Oppler, M.D.</u>				ADDRESS <u>Director, Professional Services, VAH., Perry Point, Md.</u>		DATE SIGNED <u>1-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>REMOVAL</u>		<u>1-29-56</u>		<u>Unknown</u>		<u>Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>		REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u>		24. FUNERAL DIRECTOR <u>Pennington & Son</u>		ADDRESS <u>Harre D. eGrace, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 1 1956

BUREAU V. S.

484

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Perry Point		26yrs. 4mo. 13days		TOWN Baltimore 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Veterans Administration Hospital				STREET ADDRESS (If rural give location) 617 Grantley ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
GEORGE W. COOK				January 10 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Single	8-18-93	62 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Brakeman		Penna. Railroad		Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph Cook				Isabella Griffith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
Yes WW I				unknown		Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Tuberculosis of the lungs bilateral, with						unknown	
ANTECEDENT CAUSE (S) DUE TO chronic adherent pleurisy, left							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) Coronary arteriosclerosis, moderately						unknown	
(C) Cirrhosis of the liver						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?							
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from 8-28, 1929, to 1-10, 1956, and that death occurred at 6:30a M, from the causes and on the date stated above.							
SIGNATURE J.C. Grasberger, Acting Director, Professional Services M.D. V.A. Hospital, Perry Point, Md. 1-12-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		1-12-56		Baltimore National		Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1-12-56		Diane E. Dougherty		Pennington & Son, Inc.		Baltimore, Md.	

BUREAU V. S.

RECEIVED
JAN 16 1936

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

468 CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i> Cecil </i>	MARYLAND	STATE <i> Md. </i>	COUNTY <i> Cecil </i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i> 21 Elkton </i>	LENGTH OF STAY (in this place) <i> 30 yrs. </i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i> Elkton - 21 </i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i> 00 </i>		STREET ADDRESS (If rural give location) <i> 212 W. Main Street </i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i> John Howard Davis </i>		<i> Jan 17 1956 </i>	
5. SEX: <i> male </i>	6. COLOR OR RACE: <i> white </i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i> June 14 - 1866 </i>
9. AGE last birthday <i> 89 </i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i> Farming </i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): <i> Cecil County Md. </i>
12. CITIZEN OF WHAT COUNTRY: <i> U.S.A. </i>		13. FATHER'S NAME: <i> James Thomas Davis </i>	
14. MOTHER'S MAIDEN NAME: <i> Louisa Metcalf </i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i> no </i>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i> Mrs Russell George daughter - Elkton - Md </i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i> 450.0 General Arteriosclerosis </i>			<i> 5 years </i>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i> 0 </i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i> Jan 25, 1950 </i> to <i> Jan 17, 1956 </i> that I last saw the deceased alive on <i> Jan 17, 1956 </i> and that death occurred at <i> 3:05 P.M. </i> from the causes and on the date stated above.			
SIGNATURE <i> J. H. Knight </i>		DATE SIGNED <i> Jan 18 - 56 </i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i> Burial </i>		DATE THEREOF <i> 1-21-56 </i>	
NAME OF CEMETERY OR CREMATORY <i> Cherry Hill Cemetery </i>		LOCATION (City, town, or county) (State) <i> Maryland </i>	
DATE REC'D BY LOCAL REGISTRAR <i> Jan 21 </i>		REGISTRAR'S SIGNATURE <i> J. H. Knight </i>	
24. FUNERAL DIRECTOR <i> Pappin Funeral Home </i>		ADDRESS <i> 259 E. Main St. Elkton Md. </i>	

MARGIN RESERVED FOR BINDING

RECEIVED

JAN 23 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

485
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00468
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Becil</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Becil</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
<u>Coronungo Rd.</u>		<u>6 yrs</u>		<u>Coronungo Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		<u>LOLA</u>		<u>BELLE</u>		<u>DAVIS</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED:		8. DATE OF BIRTH:	
<u>F.</u>		<u>White</u>		<u>Married</u>		<u>7-2-1890</u>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>65 yrs.</u>		<u>Housewife</u>		<u>Ash. Co N.C.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Jarris Jones</u>				<u>Bethana Phipps</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>none</u>		<u>Elongo Davis Coronungo Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Acute coronary occlusion</u>							
DUE TO							
Antecedent cause(s) (b) _____							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>W. H. Woodson</u>						<u>1-17-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 19 1956</u>		<u>Coronungo Baptist Ch</u>		<u>Coronungo Cecil Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan 17-56</u>		<u>L. M. Worthington</u>		<u>J. Earl Tyson</u>		<u>Pising Summit</u>	

BUREAU V. S.

JAN 19 1956

RECEIVED

486

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u>	LENGTH OF STAY (in this place) <u>1 month 2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cardiff</u>	<u>12 X - 2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Adm. Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Paul R. Donnan</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 13, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>4-27-89</u>
9. AGE last birthday <u>66</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Theater</u>	
11. BIRTHPLACE (State or foreign country): <u>Whiteford, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James A. Donnan</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Lane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>215 16 0416</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriolar nephrosclerosis.</u>			<u>4 years</u>
ANTECEDENT CAUSE (S) (B) <u>Diabetes Mellitus</u>			<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>12/11/</u> , 19 <u>55</u> , to <u>1/13/</u> , 19 <u>56</u> , the last day the deceased was seen and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. C. GRASBERGER</u>		DATE SIGNED <u>1/14/56</u>	
23. USUAL CREMATION? <u>Removal</u>		NAME OF CEMETERY OR CREMATORY <u>Slate Ridge</u>	
LOCATION (City, town, or county) (State) <u>Delta, Pa.</u>		24. FUNERAL DIRECTOR <u>H. HARKINS</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-14-56</u>		REGISTRAR'S SIGNATURE <u>Irvin E. Daugherty</u>	
ADDRESS <u>1/14/56</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

469

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00470

Reg. Dist.

No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Sevier</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Sevier</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town)		LENGTH OF STAY		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Elkton</u>		<u>8 yrs.</u>		TOWN <u>Elk Mills</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hosp. D.O.A.</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>Richard Harmon</u>		<u>Dove, Jr.</u>		<u>1</u> <u>14</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Mr.</u>	<u>White</u>	<u>Single</u>	<u>Aug 14 1900</u>	<u>5</u> yrs.	<u>3</u> Months	<u>5</u> Days	<u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Farmer</u>				<u>Elkton Ind.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Richard Harmon Dove, Jr.</u>				<u>Bessie Loraker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>—</u>		<u>Richard H. Dove Jr. Elk Mills</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>085.1</u> Immediate cause (a) <u>Bronchio Pneumonia</u> DUE TO Antecedent cause(s) (b) <u>3 day measles.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>1-14-56</u>					
<u>R. L. Woodson</u>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/16/56</u>		<u>Elkton Cemetery</u>		<u>Elkton</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>Jan 16</u>		<u>FR. Trager</u>		<u>W. A. Walter du Bose, Jr. Elkton, Md.</u>			

205202405

BUREAU V. S.

JAN 17 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00471

470

CERTIFICATE OF DEATH

Reg. Dist. No. 92 Kent 200

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE MD.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Elkton		Life		TOWN Rural Earleville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Union Hospital							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Harry (Middle) Duff (Last)				(Month) (Day) (Year)			
				Jan. 4. 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	May 9, 1896	59 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farm Labor		Farm Work		Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Duff				Margaret J. Culley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		215 32 1633		Thomas Duff Earleville Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				massive myocardial infarction			
ANTECEDENT CAUSE(S) DUE TO (B)				Coronary Occlusion			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Atherosclerotic Heart Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Pulmonary Embolism			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953, to Jan 1956, that I last saw the deceased alive on Jan 4 1956, 1956, and that death occurred at 11:25 A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Wallace Ovenshain M.D.				Cecilton Md. Jan 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan. 7. 1956		Cecilton Cemetery		Cecilton Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1/6/56		Edward T. Frazee		Edward T. Frazee		Millington Md	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

USUAL RESIDENCE

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

Cause of Death

DATE OF DEATH

PLACE OF DEATH

Signature

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

JAN 11 1956

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487

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>CECIL</u> MARYLAND		STATE <u>PENNSYLVANIA</u> COUNTY <u>ALLEGHENY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>PERRY POINT, MD.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PITTSBURGH</u> <u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>438 Cadet Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOSEPH J. FLEISNER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 14</u> 19 <u>56</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>March 20, 1896</u>
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unk.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Unk</u>	
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>AUTHOR FLEISNER</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records, VAH., Perry Point, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		3 5 days	
IMMEDIATE CAUSE <u>491X</u>			
ANTECEDENT CAUSE (S)		Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that <u>VA</u> attended the deceased from <u>Nov. 7, 1931</u> to <u>Jan. 14, 1956</u> , <u>that the deceased</u> <u>arrived on</u> <u>XXXXXX</u> <u>and that death occurred at</u> <u>4:05A</u> <u>M.</u> <u>from the causes and on the date stated above.</u>			
SIGNATURE <u>J. C. GRASBERGER, M.D.</u> Acting Director Professional Services, VAH., Perry Point, Md. 1/15/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
REMOVAL <u>1-15-56</u>		Unknown	
LOCATION (City, town, or county) (State)		Unknown <u>Pittsburg Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		24. FUNERAL DIRECTOR <u>Pennington & Son, Havre DeGrace, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 18 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

488
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00473

Reg. Dist.

No. 94

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Ny.</i>		COUNTY <i>Boyd.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In days)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <i>Keeler</i>		<i>1 yr</i>		TOWN <i>Westland</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Silvers Cannery</i>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <i>ERNEST</i> (Middle) (Last) <i>HART</i>				(Month) <i>1</i> (Day) <i>8</i> (Year) <i>1956</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Single</i>	8. DATE OF BIRTH: <i>June 9, 1906</i>	9. AGE last birthday: <i>49</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Cannery</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Cannery</i>		11. BIRTHPLACE (State of foreign country): <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>—</i>				14. MOTHER'S MAIDEN NAME: <i>Jessanna Hart</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <i>402-05-4759</i>		17. INFORMANT & ADDRESS: <i>Foreman Silver Cannery Leslie Ind.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
7168 Immediate cause (a) <i>Charred body.</i> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				21b. PLACE (Home, farm, factory, street, office, etc., INJURY) <i>Street</i>		21c. (City or town) (County) (State) <i>Leslie Cecil Ind.</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>1 8 56 1956</i>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Overheated Oil heater</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>W. L. Dodson</i>				M. D. ASSISTANT MEDICAL EXAM. <i>1-9-56</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>1-10-1956</i>		NAME OF CEMETERY OR CREMATORY <i>Methodist</i>		LOCATION (City, town, or county) (State) <i>North East Md</i>	
DATE REC'D BY LOCAL REG. <i>Jan 10-1956</i>		REGISTRAR'S SIGNATURE <i>Sarah E. Rothmell</i>		24. FUNERAL DIRECTOR <i>Joseph R. Grant</i>		ADDRESS <i>North East Md</i>	

BUREAU V. S.

JUN 13 1936

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00474

471

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Md		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN ELKTON		61 years		TOWN ELKTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
108 Church St.				108 Church Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
PERRY BARNES HEVERIN, JR.				1 24 1956			
5. SEX M		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MAR		8. DATE OF BIRTH 8.3.1894	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday 61 yrs.		12. CITIZEN OF WHAT COUNTRY?	
Chauffeur		Md. State Rds.				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
PERRY B. HEVERIN Sr.				Josephine LAMAR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No						Mrs. Barnes Heverin, Elkton, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				CONGESTIVE HEART FAILURE			
ANTECEDENT CAUSE(S) DUE TO				MASSIVE MYOCARDIAL OCCLUSION			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				ARTERIOSCLEROSIS (coronary heart disease)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Chronic kidneys insufficiency			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1.27, 1955, to 1.24, 1956, that I last saw the deceased alive on 1.24, 1956, and that death occurred at 2:05 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
Peter Shuster				154 W. MAIN, ELKTON, MD.			
DATE THEREOF				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
1/27/56				Elkton Cemetery		Elkton Md	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
Jan. 27, 1956				L. R. Lingers		H. Walter du Bose, Elkton, Md.	

CERTIFICATE OF DEATH

Form 10-1-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF CHIEF CLERK

20. SIGNATURE OF DEPUTY CHIEF CLERK

21. SIGNATURE OF RECORDS SECTION

22. SIGNATURE OF STATISTICS SECTION

23. SIGNATURE OF INSPECTION SECTION

24. SIGNATURE OF LABORATORY SECTION

25. SIGNATURE OF RADIATION SECTION

26. SIGNATURE OF PUBLIC HEALTH SECTION

27. SIGNATURE OF VETERINARY SECTION

28. SIGNATURE OF ZOOLOGICAL SECTION

29. SIGNATURE OF BOTANICAL SECTION

30. SIGNATURE OF AGRICULTURAL SECTION

31. SIGNATURE OF FOREST SECTION

32. SIGNATURE OF GAME SECTION

33. SIGNATURE OF FISH SECTION

34. SIGNATURE OF MARINE SECTION

35. SIGNATURE OF AQUACULTURE SECTION

36. SIGNATURE OF HORTICULTURE SECTION

37. SIGNATURE OF ANIMAL SECTION

38. SIGNATURE OF PLANT SECTION

39. SIGNATURE OF MICROBIOLOGY SECTION

40. SIGNATURE OF CHEMISTRY SECTION

41. SIGNATURE OF PHYSICS SECTION

42. SIGNATURE OF MATHEMATICS SECTION

43. SIGNATURE OF ENGINEERING SECTION

44. SIGNATURE OF ARCHITECTURE SECTION

45. SIGNATURE OF MECHANICAL SECTION

46. SIGNATURE OF ELECTRICAL SECTION

47. SIGNATURE OF CIVIL SECTION

48. SIGNATURE OF ENVIRONMENTAL SECTION

49. SIGNATURE OF OCCUPATIONAL SECTION

50. SIGNATURE OF RECREATION SECTION

BUREAU V. 2

JAN 27 1956

RECEIVED

TO VETERINARY SECTION
TO ZOOLOGICAL SECTION
TO BOTANICAL SECTION
TO AGRICULTURAL SECTION
TO FOREST SECTION
TO GAME SECTION
TO FISH SECTION
TO MARINE SECTION
TO AQUACULTURE SECTION
TO HORTICULTURE SECTION
TO ANIMAL SECTION
TO PLANT SECTION
TO MICROBIOLOGY SECTION
TO CHEMISTRY SECTION
TO PHYSICS SECTION
TO MATHEMATICS SECTION
TO ENGINEERING SECTION
TO ARCHITECTURE SECTION
TO MECHANICAL SECTION
TO ELECTRICAL SECTION
TO CIVIL SECTION
TO ENVIRONMENTAL SECTION
TO OCCUPATIONAL SECTION
TO RECREATION SECTION

489

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE D. C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Ferry Point		LENGTH OF STAY (in this place) 9 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington 47x-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital 50				STREET ADDRESS (If rural give location) 5344 Grant Street, N.E.			
3. NAME OF DECEASED: (First) GEORGE		(Middle) N.		(Last) HILL		4. DATE (Month) (Day) (Year) OF DEATH: January 5 19 56	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH: 10-4-98	9. AGE last birthday 57 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Unknown		11. BIRTHPLACE (State or foreign country): Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George Hill - Deceased				14. MOTHER'S MAIDEN NAME: Estelle Stewart - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		(If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hemorrhage inter abdominal						1 day	
ANTECEDENT CAUSE (S) DUE TO Cirrhosis of the liver						Approx. 2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-27, 1955, to 1-5-, 1956, that I last saw the deceased alive on 1-5-56, and that death occurred at 5:00 AM, from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Director, Professional Services, M.D. VAH, Perry Point, Md.		ADDRESS		DATE SIGNED 1-5-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 1-5-56		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR 1-5-56		REGISTRAR'S SIGNATURE Irene E. Dougherty		24. FUNERAL DIRECTOR Hoffman's Fun. Home, 611 K. St., N.W. Wash. D.C.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1930

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Reg. Dist. No. 92

Item 8, Film G192 2-1-56 et

1. PLACE OF DEATH:

COUNTY CECIL MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) ELKTON 2 days
 TOWN
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS Union Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY CECIL
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR ELKTON
 TOWN
 STREET (If rural give location)
 ADDRESS 202 BLUE BALL STR.

3. NAME OF DECEASED:

(First) (Middle) (Last)
ANNIE V. HOLMES
 (Type or Print)

4. DATE (Month) (Day) (Year)
 OF DEATH: 1 22 1956

5. SEX:
F

6. COLOR OR RACE:
W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MAR.

8. DATE OF BIRTH: 1881
Nov. 10, 1881

9. AGE Last birthday: 74 yrs. If UNDER 1 YEAR If UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): PHILADELPHIA, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

JAMES McDONALD

14. MOTHER'S MAIDEN NAME:

Mrs. Ester Rittenhouse, Elkton, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Mrs. Ester Rittenhouse, Elkton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) MASSIVE CEREBRAL HEMORRHAGE 2 days
 DUE TO
 Antecedent causes (s) (b) CVA 2 days
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO
 260X (c) CEREBRAL VASCULAR SCLEROSIS 5-6 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

DIABETES MELLITUS

19a. DATE OF OPERATION:

0

19b. MAJOR FINDINGS OF OPERATION

0

Interval Between Onset And Death

2 days

2 days

5-6 years

20 years?

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

INJURY OCCURRED
 While at Not While
 Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1:17, 1956, to 1:22, 1956, that I last saw the deceased

alive on 1:22, 1956, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL, (Specify)

Burial
 DATE REC'D BY LOCAL REGISTRAR

DATE THEREOF

Jan 24, 1956

NAME OF CEMETERY OR CREMATORY

Friends

LOCATION (City, town, or county)

Calvert, Cecil Co

(State)

md

REGISTRAR'S SIGNATURE

H. H. Hager

24. FUNERAL DIRECTOR

Joseph R. Hunt

ADDRESS

North East Md

BUREAU V. S.

JAN 25 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00477

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Elkton		70 Yrs		TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
404 North St.				404 North St.			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
Julia A Juergens			JAN. 1			1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	WH	Widow	Aug. 15, 1865	90	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
At Home		House wife		Ireland		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Benard Pryer				Susan Mulvaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Mrs Emma Kincaid Elkton, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) Pulmonary edema						2 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cardiovascular renal						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/31, 1955, to 1/1, 1956, that I last saw the deceased alive on 12/31, 1955, and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
SIGNATURE J. Rodney Freyer				ADDRESS Elkton Md		DATE SIGNED 1/2/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan 4/56		Catholic		Elkton Md	
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JAN 5 1956		J. Rodney Freyer		Pippin Funeral Home		Elkton, Md.	
DATE				By Pippin			

BUREAU V. S.

JAN 5 1956

RECEIVED
JAN 5 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00478

490

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Port Deposit</i>		<i>Life</i>		TOWN <i>Port Deposit</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Main St</i>				STREET ADDRESS (If rural give location) <i>Main St</i>			
3. NAME OF DECEASED (Type or Print) <i>Blanche</i> (First) <i>Krauss</i> (Middle) (Last)				4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>29</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 8, 1879</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Abraham Hasson</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Kelly</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Joseph Mitchell, Port Deposit, Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio-Sclerosis</i>				<i>10 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>269X</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Dialysis</i>				<i>12 yrs</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <i>Jan 26, 1956</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 26, 1956, to Jan 29, 1956, that I last saw the deceased alive on Jan 26, 1956, and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
SIGNATURE <i>B. Hasson</i>		M.D.		ADDRESS (Street, city, town, state) <i>Port Deposit, Md</i>		DATE SIGNED <i>1/30/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-31-1956</i>		NAME OF CEMETERY OR CREMATORY <i>West Nottingham</i>		LOCATION (City, town, or county) (State) <i>Colora, Md</i>	
24. REC'D BY REGISTRAR <i>1-31-1956</i>		REGISTRAR'S SIGNATURE <i>Irene E. Daugherty</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. A. Patterson & Son</i>		ADDRESS <i>Perryville, Md</i>	

00738

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

590

Reg. Lib. No.

NAME OF DECEASED (Print Name in Full)

DATE OF DEATH

AGE (Years, Months, Days)

SEX

PLACE OF BIRTH

CAUSE OF DEATH (Print Name of Disease)

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PREVIOUS CAUSE

OTHER CAUSE

PLACE OF DEATH

AT HOME

IN HOSPITAL

DATE OF BURIAL

PLACE OF BURIAL

NAME OF BURIAL PLACE

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF FUNERAL HOME

NAME OF CARRIER

NAME OF DRIVER

NAME OF ASSISTANT

NAME OF ATTENDANT

NAME OF BELLMAN

NAME OF PORTER

NAME OF COOK

NAME OF BUTLER

NAME OF MAID

NAME OF SERVANT

NAME OF GROOM

NAME OF Usher

NAME of Organist

NAME of Soloist

NAME of Chorist

NAME of Cantor

NAME of Reader

NAME of Deacon

NAME of Acolyte

NAME of Censer Bearer

NAME of Candle Bearer

NAME of Procession Leader

NAME of Officiant

NAME of Celebrant

NAME of Concelebrant

NAME of Officiant

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

491

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00479

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Port Deposit</u>		<u>70 yrs</u>		TOWN <u>Port Deposit</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>83 North Main St.</u>				STREET ADDRESS (If rural give location) <u>83 North Main</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Chester</u>		(Middle) <u>Arthur</u>		(Last) <u>Krauss</u>		(Month) (Day) (Year) <u>Jan. 2 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 25, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen R. Krauss</u>				14. MOTHER'S MAIDEN NAME <u>Anna Barr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-6165</u>		17. INFORMANT & ADDRESS <u>Chester A. Krauss Jr. Port Deposit</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr =</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Arterio Sclerosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 14, 19 55</u> , to <u>Dec - 31, 55</u> , that I last saw the deceased alive on <u>Dec 31 - 19 55</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.							
SIGNATURE <u>B. Benson</u>				DATE SIGNED <u>Port Deposit, Md - Jan-2-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-5-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leola Patterson & Son, Perryville, Md</u>		ADDRESS	
DATE <u>1-5-1956</u>							

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Time of death (Hour, minute)

7. Cause of death (Print or write full name)

8. Place of death (City, State, Country)

9. Signature of physician (Print or write full name)

10. Signature of registrar (Print or write full name)

11. Signature of undertaker (Print or write full name)

12. Signature of funeral home (Print or write full name)

13. Signature of cemetery (Print or write full name)

14. Signature of church (Print or write full name)

15. Signature of other (Print or write full name)

16. Signature of other (Print or write full name)

17. Signature of other (Print or write full name)

18. Signature of other (Print or write full name)

19. Signature of other (Print or write full name)

20. Signature of other (Print or write full name)

21. Signature of other (Print or write full name)

22. Signature of other (Print or write full name)

23. Signature of other (Print or write full name)

24. Signature of other (Print or write full name)

25. Signature of other (Print or write full name)

26. Signature of other (Print or write full name)

27. Signature of other (Print or write full name)

28. Signature of other (Print or write full name)

29. Signature of other (Print or write full name)

30. Signature of other (Print or write full name)

31. Signature of other (Print or write full name)

32. Signature of other (Print or write full name)

33. Signature of other (Print or write full name)

BUREAU V. S.

JAN 9 1936

RECEIVED

John Littlejohn for funeral home

SHORTLY AFTER

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Cecil</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u> TOWN <u>Colora</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colora</u> STREET ADDRESS (If rural give location) <u>X</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Doctor Clark Lucas</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 31 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>September 15, 1880</u> 75 yrs.
9. AGE last birthday: <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Floyd, Va.</u>	
11. BIRTHPLACE (State or foreign country): <u>Floyd, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Jack Lucas</u>		14. MOTHER'S MAIDEN NAME: <u>Priscilla Artizer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-8643A</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Carl M. Edmondson Delta, Pa.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) <u>Coronary Thrombosis</u> (B) <u>Coronary Sclerosis</u> (C) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1952</u> to <u>Jan 31, 1956</u> that I last saw the deceased alive on <u>11-29</u> , 1956, and that death occurred at <u>11 P</u> M, from the causes and on the date stated above. SIGNATURE <u>Orville R. Taylor</u> ADDRESS <u>00</u> M. D. <u>00</u> DATE SIGNED <u>2/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 3, 1956</u> NAME OF CEMETERY OR CREMATORY <u>Darlington Cem.</u> LOCATION (City, town, or county) (State) <u>Darlington Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 2 1956</u>		REGISTRAR'S SIGNATURE <u>L. M. Worthington</u> 24. FUNERAL DIRECTOR ADDRESS <u>J. Earl Tyson Rising Sun, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1956

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Missouri</u>		COUNTY <u>Taney</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bainbridge</u>		<u>29 days</u>		TOWN <u>Branson</u>		<u>62 x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>708 Brown Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ISABEL</u> (N) <u>MEADOWS</u>				<u>1</u> <u>18</u> <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Malayan</u>	<u>married</u>	<u>2-6-18</u>	<u>37</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>-----</u>		<u>Housewife</u>		<u>Manila, Phillipine Island</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>LAMBERTO DE LEON</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>-----</u>		<u>-----</u>		<u>Navv Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592x IMMEDIATE CAUSE (A) <u>UREMIA</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>Approx. 30 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>HYPERTENSION - SEVERE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-20</u> , 19 <u>55</u> , to <u>1-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>56</u> , and that death occurred at <u>3:57 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Till</u>				DATE SIGNED			
W. H. TILL, LT (MC) USNR				M.D. U. S. NAVAL HOSPITAL, BAINBRIDGE, MD. 1-19-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal & Burial</u>		<u>1-19-56</u>		<u>Branson Cemetery</u>		<u>Branson Missouri</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>1-18-56</u>		<u>Dorothy B. Beamble</u>		<u>Veera Patterson & Son, Perryville, Md.</u>			

death certificate assembly should be detached for use in transit permit.

CERTIFICATE OF DEATH

Form No. 100

1. Usual Residence (House or Apartment)

2. Place of Death

3. Date of Death
 4. Time of Death
 5. Age
 6. Sex
 7. Race
 8. Marital Status
 9. Occupation

10. Cause of Death
 11. Manner of Death

12. Signature of Physician
 13. Signature of Registrar

14. Signature of Informant
 15. Address of Informant

16. Signature of Registrar

17. Date of Registration

18. Signature of Registrar

19. Signature of Registrar

20. Signature of Registrar

21. Signature of Registrar

22. Signature of Registrar

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53. Signature of Registrar

54. Signature of Registrar

55. Signature of Registrar

56. Signature of Registrar

BUREAU V. 3

JAN 29 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 00482

No. 94

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Sevier</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Sevier</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>North East</u>		LENGTH OF STAY (in this place) <u>3 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>North East</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beach & Main</u>				STREET ADDRESS (If rural, give location) <u>Beach & Main St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>DANIEL</u> <u>Brosworth</u> <u>Moatz</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>1</u> <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH: <u>2-16-1901</u>	
9. AGE last birthday: <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done, during most of work life, even if retired) <u>Food Products</u>		11. BIRTHPLACE (State or foreign country): <u>Ill. Creek, N. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Mitchell Moatz</u>				14. MOTHER'S MAIDEN NAME: <u>Miss Daniel B. Moatz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>235-05-8471</u>		17. INFORMANT & ADDRESS: <u>Miss Daniel B. Moatz North East Ind.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1</u> <u>Acute Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. L. Woodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-1-56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1-5-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Gilpin Memorial Cemetery</u>		LOCATION (City, town, or county) (State): <u>Rehoboth Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-3-1956</u>		REGISTRAR'S SIGNATURE: <u>Sarah C. Rothermel</u>		24. FUNERAL DIRECTOR: <u>Joseph R. Grant</u>		ADDRESS: <u>North East, Ind.</u>	

RECEIVED

JAN 6 1952

BUREAU V. S.

495

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE (D. C.) Md.		COUNTY P.G.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
X TOWN Perry Point		4yrs. 5 mo.		TOWN Washington		16X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 Veterans Administration Hospital				7105 Oxon Hill Road, S.E.			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
DECEASED: DANIEL		L.		PATE		OF DEATH: January 9 1956	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: 5-3-76	
9. AGE last birthday: 79 yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard				10B. KIND OF BUSINESS OR INDUSTRY: Government -		11. BIRTHPLACE (State or foreign country): North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes S.A.W.				16. SOCIAL SECURITY NO. 218 240 008		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE				(A) Thrombosis left anterior cerebral artery			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) Arteriosclerosis, generalized and cerebral, severe			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-9, 1951, to 1-9, 1956, that I last saw the deceased on 1-10-56, and that death occurred at 11:50a M, from the causes and on the date stated above.							
SIGNATURE W. Oppler				ADDRESS VAH, Perry Point, Md.		DATE SIGNED 1-10-56	
W. OPPLER, Director, Professional Services, M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		1-10-56		Arlington National		Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR 1-11-56		REGISTRAR'S SIGNATURE Irene E. Dougherty		24. FUNERAL DIRECTOR Pennington & Son		ADDRESS Havre de Grace, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

RECEIVED
JUN 18 1958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

496

00484

Reg. Dist. 96

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>leecil</u>	MARYLAND	STATE <u>md</u> COUNTY <u>leecil</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
X TOWN <u>leconungo</u>	<u>all life</u>	TOWN <u>leconungo</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>mt gae</u>		STREET ADDRESS (If rural, give location) <u>mt gae</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>JOSEPH</u>		<u>PETERS</u> 1 10 1956	
5. SEX <u>M</u>	6. COLOR OF SKIN <u>Cal</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>no information</u>	8. DATE OF BIRTH: <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY: <u>any kind of work</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>Levi Peters</u>		14. MOTHER'S MAIDEN NAME: <u>Isabelle Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>Bertha Brown. Port Deposit md</u>	
17. INFORMANT & ADDRESS: <u>Bertha Brown. Port Deposit md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>443x Myocarditis & Hypertension</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>A. L. Dackman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>1-11-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-13-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>mt goar</u>		LOCATION (City, town, or county) (State) <u>leconungo, md</u>	
DATE REC'D BY LOCAL REG. <u>1-13-1956</u>		24. FUNERAL DIRECTOR <u>W. A. Patterson & Son, Perryville, Md</u>	
REGISTRAR'S SIGNATURE <u>Irene E. Daugherty</u>		ADDRESS	

RECEIVED

JAN 16 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

497

00485

Reg. Dist. No. 97

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Bainbridge		LENGTH OF STAY (in this place) 2 hrs.		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural, give location) 325 Hollingsworth Manor			
3. NAME OF DECEASED: (Type or Print)		(First) RICHARD		(Middle) BUDDY		(Last) PROPPS, JR.	
4. DATE OF DEATH		(Month) JAN		(Day) 2		(Year) 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 4-16-55	9. AGE last birthday: yrs. 8		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Bainbridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Richard Buddy PROPPS, SR.				14. MOTHER'S MAIDEN NAME: Geraldine GRIFFIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Navy Records	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
057.1 Immediate cause (a) BRONCHOPNEUMONIA WITH WATERHOUSE-FREDRICKSON DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <input checked="" type="checkbox"/> 1-3-56 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial		DATE THEREOF 1-3-56		NAME OF CEMETERY OR CREMATORY Gilpin Manor Cemetery		LOCATION (City, town, or county) (State) Elkton Maryland	
DATE REC'D BY LOCAL REG. 1-3-56		REGISTRAR'S SIGNATURE Dorothy B. Bramble		24. FUNERAL DIRECTOR		ADDRESS	
				Peppan Funeral Home		Elkton, Md	
2051 212396						Bj 277	

RECEIVED

JAN 5 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: 474		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Maryland	COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton	LENGTH OF STAY (in this place) 16 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN E North East	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital-Elkton	STREET ADDRESS (If rural give location) Elkton Cecil Avenue		
3. NAME OF DECEASED: (First) Maude (Middle) Leedom (Last) Rose		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 28, 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: Oct 20, 1874
9. AGE last birthday 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	11. BIRTHPLACE (State or foreign country): Bay View Cecil Co Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: Edward T. Leedom	
14. MOTHER'S MAIDEN NAME: Mary Tyson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-24-7535		17. INFORMANT & ADDRESS: Francis Rose North East, Md	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Respiratory and Cardiac failure			
ANTECEDENT CAUSE (B) Carcinoma of lungs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pleural effusion			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 6, 19 56 to Jan 28, 19 56 , that I last saw the deceased alive on Jan 28, 19 56 , and that death occurred at 11 A. M. from the causes and on the date stated above.			
SIGNATURE Arthur Centurion		DATE SIGNED Jan 28/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 10 unaid		24. FUNERAL DIRECTOR ADDRESS Joseph R. Lusk North East Md	
DATE REC'D BY LOCAL REGISTRAR Jan 30		REGISTRAR'S SIGNATURE FR. Lusk	

BUREAU V. S.

FEB 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

00487

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH- COUNTY <i> Cecil </i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i> Delaware </i> COUNTY <i> N. C. </i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i> Warwick </i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i> Townsend, Rural </i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i> 46 X-3 </i>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i> Benedict C. Savin </i>		4. DATE OF DEATH (Month) (Day) (Year) <i> 1-5-56 </i>	
5. SEX <i> Male </i>	6. COLOR OR RACE <i> White </i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i> Married </i>	8. DATE OF BIRTH <i> 3-16-1902 </i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i> Farmer </i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i> 53 </i> yrs.
11. BIRTHPLACE (State or foreign country) <i> Md </i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i> James Savin </i>		14. MOTHER'S MAIDEN NAME <i> Mary Ann Holden </i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <i> Augustine Savin Middletown Del. </i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

 Articular Fibrillation

Antecedent cause(s)

(b)

 Coronary Artery disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While	HOW DID INJURY OCCUR?		
OF INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from *Jan 5* , 19 *55* , to *Jan 5* , 19 *56* , that I last saw the deceased alive on *Jan 5* , 19 *56* , and that death occurred at *11 A.* m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i> Buried </i>	<i> 1-8-56 </i>	<i> Warwick Cemetery </i>	<i> Warwick Md. </i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i> January 7-1956 </i>	<i> Paul Ralph H. Bell </i>	<i> G. J. L. Daniels </i>	<i> Middletown Del. </i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1956

RECEIVED

499

CERTIFICATE OF DEATH

WC Reg. Dist. No. 96

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN Perry Point		7 mo. 19 days		TOWN Baltimore 3Y01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 428 N. Gilmore			
3. NAME OF DECEASED: (First) EUGENE		(Middle) (NMI)		(Last) SHAW		4. DATE (Month) (Day) (Year) OF DEATH: January 25 19 56	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 11-20-92	9. AGE last birthday: 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Head Waiter		10B. KIND OF BUSINESS OR INDUSTRY: Mess Hall - V.A.		11. BIRTHPLACE (State or foreign country): North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Hospital Ephraim Shaw - Deceased				14. MOTHER'S MAIDEN NAME: Julia Johnson - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Peritonitis diffuse						7 to 10 days	
ANTECEDENT CAUSE (S) (B) Carcinomatosis with rupture of the small bowel						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Carcinoma of the head of the pancreas						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary congestion and edema						3 to 4 days	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-6, 1955, to 1-25, 1956, and that death occurred at 9:40 PM, from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Director, Professional Services				DATE SIGNED 1-26-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 1-26-56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 1-27-56		REGISTRAR'S SIGNATURE Irene E. Dougherty		24. FUNERAL DIRECTOR ADDRESS		Perry Point, Md.	

BUREAU V. S.

JAN 30 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 00489

No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (to this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
X TOWN <u>Elkton</u>		<u>32 hr.</u>		TOWN <u>Elkton Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dogwood Road.</u>				STREET ADDRESS (If rural, give location) <u>Dogwood Road.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>GUYLES</u>		(Middle)		(Last) <u>SOULE</u>		(Month) (Day) (Year) <u>1 31 19 66</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Sept 17, 1919</u>	9. AGE last birthday: <u>36</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY: <u>Saw Sharpens</u>		11. BIRTHPLACE (State or foreign country): <u>Linden, N.Y.</u>	Months		Days
13. FATHER'S NAME: <u>Herbert E Soule</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME: <u>Grand Baker</u>			
16. SOCIAL SECURITY No.: <u>Pippin Funeral Home Elkton Md</u>				17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Charred Body.</u>							
DUE TO							
Antecedent cause(s) (b) <u>giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, OF street, office, bldg., etc.) INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Elkton Cecil Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1 31 56 8:15</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Overheated Stove Set fire to shack.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>A L Doelner</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>1-31-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 1 1956</u>		NAME OF CEMETERY OR CREMATORY <u>West Canton N.Y.</u>		LOCATION (City, town, or county) (State) <u>West Canton N.Y.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 1</u>		REGISTRAR'S SIGNATURE <u>FR Frazier</u>		FUNERAL DIRECTOR <u>Pippin Funeral Home</u>		ADDRESS <u>Elkton Md.</u>	

RECEIVED

FEB 2 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point,		LENGTH OF STAY (in this place) 2 mo. 27 days		CITY (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural give location) 5200 Kansas Avenue, N.W.					
3. NAME OF DECEASED: (Type or Print)		(First) LAWRENCE		(Middle) W.		(Last) TRUMBULL	
4. DATE OF DEATH:		(Month) January		(Day) 13		(Year) 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: 12-4-95	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY: Government Printing		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Trumbull (Deceased)				14. MOTHER'S MAIDEN NAME: Aurglia Curtis (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. Unknwon		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Hemorrhage from cerebral vessels		2 Minutes
ANTECEDENT CAUSE (S) due to Trauma (Electric Shock)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic Cardiovascular Disease		10 Years
---	--	-----------------

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **10-17**, 1955, to **1-13**, 1956, and that death occurred at **9:05 AM**, from the causes and on the date stated above.

SIGNATURE **Joseph C. Grasberger, Acting Chief,** ADDRESS **VAH, Perry Point, Md.** DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) **Removal** DATE THEREOF **1-13-56** NAME OF CEMETERY OR CREMATORY **Arlington National** LOCATION (City, town, or county) (State) **Arlington, Virginia**

DATE REC'D BY LOCAL REGISTRAR **1-13-56** REGISTRAR'S SIGNATURE **Irrene E. Dougherty** 24. FUNERAL DIRECTOR **W.W. CHAMBERS** ADDRESS **1400 Chapin St, N.W. Wash., D.C.**

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 96.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY CECIL		MARYLAND		STATE MARYLAND		COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X/ TOWN PERRY POINT		7 DAYS		BALTIMORE 3Y01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 Veterans Administration Hospital				602 N. CARROLLTON AVENUE ✓			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year) OF DEATH	
JOHN		HENRY		WALKER		January 20, 1956	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
Male	Negro	Married	May 5, 1895	60 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Waiter		RR Dining Car		Washington, D.C.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
George Walker				Margaret Nelson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
Yes ✓ WW-I		719 07 0641		Hospital Records, VAH., Perry Point, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE				(A) <u>Bronchopneumonia, bilateral unresolved</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Myocardial fibrosis</u>			
				DUE TO			
				(C) <u>Coronary Sclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, generalized, severe</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
VA		M.					
22. I hereby certify that I attended the deceased from Jan. 13, 1956, to Jan. 20, 1956, and that death occurred at 6:15 P.M. from the causes and on the date stated above.							
SIGNATURE <u>E. S. ELLS, M.D.</u>				ADDRESS		DATE SIGNED	
E. S. ELLS, M.D., Professional Service.				M. D. VAH, Perry Point, Md.		1-21-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
REMOVAL		1-22-56		Arlington National		Ft. Myer, Virginia.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1-24-56		<u>James E. Dougherty</u>		<u>Pennington & Son</u>		Havre DeGrace, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 26 1956

BUREAU V. S.

503 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		LENGTH OF STAY (in this place) <u>4 yrs 26 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VA Hospital</u>				STREET ADDRESS (If rural give location) <u>320 Radnor Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Paul R. Waller</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>January 7, 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-20-94</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Agent</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Insurance</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Richard Waller</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Rider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk): <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-07-2933</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 9, 1951</u> , to <u>Dec 9, 1956</u> , and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>William M. Harris M.D.</u>				ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>1-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>New Freedom, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-8-56</u>		REGISTRAR'S SIGNATURE <u>Gene E. Daugherty</u>		24. FUNERAL DIRECTOR <u>Jenkins Funeral Home, Balt., Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 10 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 92

475

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
21 TOWN Eketon		1 day		TOWN Childs			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
65 Union Hospital				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Ella White				Jan. 24 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	April 20 1906	49 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Homemaker				Virginia		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Andy Andrews				Lucy Hester			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
		—		Robert C. White,			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) Broncho pneumonia							1/22
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Thrombosis							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 1954, to Jan 24, 1956, that I last saw the deceased alive on Jan 22, 1956, and that death occurred at 11:37 M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
Dorland H. Spreecher M.D.				Eketon, Md.		Jan 24, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-26-56		Union Cemetery		Eketon (Rural) Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Jan 25		JH Frazer		Joseph R. Grant		North East, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

COUNTY CECIL MARYLAND
 CITY (If outside corporate limits, write RURAL) LENGTH OF STAY
 OR and give nearest town) (in this place)
 TOWN ELKTON 2 days
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY CECIL
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN ELKTON X
 STREET ADDRESS (If rural give location)
RFD #3. 1

3. NAME OF DECEASED:

(First) (Middle) (Last)
KAREN S. WOODIE

4. DATE (Month) (Day) (Year)
 OF DEATH: 1 5 1956

5. SEX:
F

6. COLOR OR RACE:
W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
Child

8. DATE OF BIRTH:
May 2, 1954

9. AGE last birthday
1 yrs. 8 Months 2 Days 3 Hours 1 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
Child

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):
Elkton, Md

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME:

Junior W. Woodie

14. MOTHER'S MAIDEN NAME:

Louise B. Lerena

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Junior W. Woodie RFD #3 Elkton

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0

IMMEDIATE CAUSE

(A)

ACUTE METABOLIC ACIDOSIS

INTERVAL BETWEEN ONSET AND DEATH
24 hours

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.

(B)

ACUTE GASTRO-ENTERITIS

48 hours

(C)

? Undermined infection?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Nutritional anemia

Four months

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
 YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1:3, 1956 to 1:5, 1956 that I last saw the deceased alive on 1:5, 1956 and that death occurred at 7:45 AM, from the causes and on the date stated above.

SIGNATURE

Peter Shukis

ADDRESS

DATE SIGNED

M. D.

154 W. MAIN, ELKTON, MD. 1:6:56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 6

JR. J. J. J.

Pepper General Home Elkton, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1956

RECEIVED